Queensland Government Department of Natural Resources and Mines

Trevor George DOMROW

Findings and Recommendations

[Schedule A] [Schedule B] [Schedule C] [Schedule D] [Schedule E]

The *Coal Mining Act 1925* (as amended) -

Findings and recommendations of reviewers and mining warden following an inquiry into fatal injuries received by Trevor George Domrow at Newhill Colliery on 25 march 1997 Warden's Court of Queensland Brisbane 28-29 october 1997.

Before: Mr A J Chilcott, esquire acting mining warden

Reviewers:

- Professor David Rowlands
- Mr Ray Parkin
- Mr John Patrick Brady
- Mr Denis Hansell

To assist:

Ms Margaret Maloney, barrister instructed by crown solicitors office for inspectorate

Appearances:

- Mr William Mead Allison for Construction Forestry, Mining & Energy Union (CFMEU) and next of kin, Mrs S Domrow.
- Mr R Dickson, barrister instructed by Messrs Standish Partners, solicitors for Newhill Coal Pty Ltd.

Witnesses examined: refer transcript and schedule "a"

Exhibits tendered: refer transcript and schedule "b"

Findings: refer transcript and schedule "c"

Recommendations: refer transcript and schedule "d"

Report of mining warden: refer transcript and schedule "e"

Schedule "A" Witnesses examined:

- Dr Russell Frith

- Inspector Walter Herbert English
- Gregory Joseph Rowan
- Glen Thomas Rew
- Mervyn Stanley Knack
- Trevor Lesley Hemley
- Robert Samuel Bitmead

Schedule "B" List of Exhibits

No of Exhibit	Nature of Exhibit	Tendered by
1	Letter of Dr D G McAdam dated 3 October 1997	Ms Maloney
Ex A for Ident	Report of Investigating Officer - Wal English	"
2	Report of Investigating Officer - Wal English (Formerly Exhibit A for Identification)	"
3	Approved Standard for Mine Safety Management Plan	"
4	Report of Mine Manager - Greg Rowan	"

Schedule "C" Findings:

We find -

Name of deceased: Trevor George Domrow

Date of fatal injury: 25 march 1997

Place of accident: Ipswich Hospital

Cause of death: From the medical certificate tendered:-

1(a) Chest injuries

Nature of accident:

At about 9.15 pm on tuesday 25th March 1997 Mr Trevor Domrow, section deputy, received serious injuries from the toppling of a large lump of coal (3.5 metres long, 0.5 metres thick and 1.0 metres high) from the south east unsupported rib adjacent to survey station 149 in the no.1 south west panel. (refer plan No. G13 - exhibit 2.)

At the time of the accident Mr Domrow was carrying out repairs to the left hand side roof bolter of the continuous miner.

He subsequently died as a result of these injuries at Ipswich hospital at 11-04 pm on that date.

Prior to the accident and in accordance with the normal mining sequence, a left hand break-off had been formed off the conveyor belt roadway. The face had been advanced about ten (10) metres from the intersection. Mining operations had continued without incident and no unusual conditions were evident.

The production crew had just completed scaling down the left hand rib adjacent to the accident site using the head of the continuous miner, a remote controlled, Joy 12 CM 12. Loose coal was loaded onto a shuttle car and the continuous miner was trammed back from the face and positioned for the installation of roof bolts.

Before these roof bolting operations were to commence, Mr Domrow noticed that a hydraulic fitting on the left-hand, machine mounted bolting rig had been damaged. This fitting was leaking hydraulic oil which effectively disabled the bolting rig.

Mr Domrow instructed the miner operator, Mr Rew, to withdraw the continuous miner outbye and away from the rib which was cracked and appeared unstable. The miner was moved about 2 to 3 metres and after an inspection of the rib, Mr Domrow instructed that the machine be withdrawn further. The continuous miner was moved another 2 to 3 metres. This area was examined by Mr

Domrow and the shuttle car driver, Mr Knack, and these men concluded that the rib was stable and therefore safe to commence repairs to the bolting rig.

Shortly after, these two men were joined by the continuous miner operator, Mr Rew, and repairs to the machine were commenced.

Mr Domrow was bending around the unit when the under manager, Mr Bitmead, observed movement in the upper portion of the rib. He immediately shouted a warning, however, a large portion of the upper rib toppled over striking Mr Domrow and, to a lesser degree, Mr Rew and Mr Knack.

Mr Domrow, who was seriously injured, was removed very quickly by those present who should be commended for their valiant efforts in removing him from further danger and transporting him to the surface without undue delay.

We are of the opinion that the method of strata support offered little protection from rib spall. No effective rib support was required by the managers support rules, nor any installed as a matter of choice by the persons working at this particular place.

Cause of accident:

We are of the opinion that the workplace contained a number of hazards that were not realised by those present.

These include:-

- Mining induced fractures along a secondary cleat or joint plane;
- Orientation of the roadway in relation to the secondary cleat direction;
- Unsecured rib coal.

By not realising these hazards existed, Messrs Domrow, Rew and Knack placed themselves in a hazardous position between the continuous miner and the coal rib.

Schedule "D" Recommendations:

The recommendations of the reviewers are as follows:

- The Queensland Department of Mines and Energy require mine operators to prepare safety plans for "Strata Management". These plans must address the support systems required for both roof and sides of mining excavations. The support systems must take account of pre-mining stresses and mining induced stresses. In essence the support systems should be designed to maintain the physical integrity of both roof and rib elements so that they can safely withstand the sum total of the pre-mining and mining induced stresses. The following factors need to be considered in the development of "Strata Management Plans":-
    - The systematic support of the roof and ribs;
    - A sequence plan showing positions, intervals and types of support;
    - Wherever maintenance work is to be carried out underground on equipment, a procedure must be in place to ensure that the roof and sides are adequately supported;
    - The relationship between seam dip and excavated section on rib failure hazards.
- The development of strata management plans requires risk assessment using geotechnical information.
- Mine operators should establish and maintain a systematic audit process, to ensure that the plans and procedures have been properly implemented and reviewed.
- All personnel must receive competency based training to implement the requirements of the strata management plans.

Schedule "E" Report of the Warden:

Having delivered, the findings as to the nature and cause of the accident and the recommendations, I deliver the following report.

I express my sincere thanks to Ms Maloney for her assistance with regard to this inquiry. I would also like to thank the reviewers and my clerk for their time and assistance during this inquiry.

In conclusion, I concur with the findings of the reviewers as to the nature and cause of the accident.

The inquiry is now closed.

29 october 1997

Last Updated 21 October 2007

Great state. Great opportunity.